Read insti

HMO In

Read instructions before completing form FIS 0320 (10/06) Office of Financial & Insurance Services HMO Inpatient Discharges & Benefit Payouts Report		Filing is required for: All HMOs	2007		
			DUE quarterly		
File with your quarterly and annual statements. Provide data	a based on calendar year.	Bar Code Required - Place Bar Code Here			
Name of HMO	NAIC Group number and Co. code	Indicate 2006 Annual data DUE March 1, 2007 which Q1 data DUE May 15, 2007 report you Q2 YTD DUE August 15, 2007 are filing. Q3 YTD DUE November 15, 2007			
Section 1-Contracted Hospitals Attach additional sheet(s	s) if necessary.				
Name of contracted hospital		Total number of In Elective Emerg			

Subtotals:

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Section 2-NON-Contracted Hospitals	Total number of Inpatient Discharges				
Name of NON-Contracted hospital		Elective	Emergency	rcharges Total	
		Subtotals:			
0 (0 0 0 1 0 0 () (
Section 3-Discharge Statistics	Floring Investigat Dischause from	Flootiss lovet	ant Diaghanna from	TOTAL Flective In	nationt Discharges
	Elective Inpatient Discharges from Contracted Hospitals	Elective Inpatient Discharges from NON-Contracted Hospitals		TOTAL Elective Inpatient Discharges from Contracted AND NON-Contracted	
				Hos	pitals
Number of Discharges					
Percentage of Discharges	%		%	1	00%
Enter amount (in doll	ars) of 3 month projected incurred claims from	non-contract hospi	tals	\$	
,	,	·		Ψ	
Section 4-Total Benefit Payouts					
			enefit Payout	Percentage	of Payments
Total payments to contracted providers	•	\$		%	
Total payments under Hospital Access Agreement (Medicaid only)		\$		%	
Total payments to non-contracted providers		\$		%	
Total medical and hospital expenses pa	aid	\$			100%
Section 5-Interrogatories					
	actice or managed care errors and omissi	ons coverage?	Yes	No If yes, pl	ease complete below:
Name of carrrier		Limits of coverage		Expiration date	
Contistantion					
Certification I certify that I am an officer of the HMO I	named in this report, and that I have authority	v to prepare and file	this report. I have exam	ined this report thorou	ghlv. and it is true.
complete and correct to the best of my k		,			3, ,
Signature Date signed			Person and phone number to contact regarding this report		s report
Signer's name and title typed or printed					

PA 218 of 1956 as amended requires submission of this form by all licensed Health Maintenance Organizations. Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.



Michigan Department of Labor & Economic Growth

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